



### **Consent for Minor Dental Treatment & Release of Information**

I, the undersigned parent or legal guardian of the child listed below, hereby authorize the individual(s) listed below (other than the parent/legal guardian) to bring my child to **Kids Dental Center** for dental appointments and treatment.

I further authorize Kids Dental Center and its dentists to disclose and discuss my child's dental and related medical information with the individual(s) listed below as it pertains to my child's care. This includes, but is not limited to, appointment scheduling, treatment plans, and recommendations.

This authorization shall remain in effect until revoked in writing. I understand that I may revoke this consent at any time by submitting a written request to Kids Dental Center.

**Child's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Authorized Individual(s):**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**Parent/Legal Guardian Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_